GUIDELINES TO DOCTORS ON REPORTING DEATHS TO THE CORONER
1.0 Purpose

To provide guidance to doctors on the occasions when there is a need to report a death to the coroner.

2.0 Area

This guideline applies Trustwide.

3.0 Duties

The guideline relates to all registered medical practitioners. The duties and responsibilities are listed in the following sections.

4.0 Actions

4.1 General principles

4.1.1 When a patient dies who has been under your care (you being either a member of a clinical team or the consultant leading the team) there are certain legal obligations placed upon you. In most cases you will need to complete a Medical Certificate of Cause of Death or \textbf{MCCD} (death certificate). On occasions you will need to report a case to the Coroner and this paper is an attempt to provide you with guidance in the latter circumstance.

4.1.2 As a registered medical practitioner, if a patient dies under your care (i.e. you attended them in their last illness) you have a legal obligation to complete a death certificate stating “to the best of (your) knowledge and belief” the likely cause of death. This is not a duty that can be delegated to non-medical staff. In most cases this is straightforward and is undertaken as a matter of routine.

4.2 Death certification by doctors

4.2.1 A licensed qualified medical practitioner should not sign a \textbf{MCCD} in respect of a death from wholly natural causes unless:

- he/she is satisfied as to the cause of death; and
- he/she is satisfied that the death is entirely natural; and
- he/she has attended (meaning assessed and/or treated) the patient during the patient's last illness; and either:
  
  (a) such attendance was during the previous 14 days, or
  
  (b) he / she has viewed the body after death

\footnote{Births & Deaths Registration Act 1953}
Guidance note: In practice, Trust doctors will have seen the patient within the previous 14 days and will not need to have regard to paragraph (b) above, which is aimed primarily at General Practitioners in the community.

4.2.2 The Registrar of Deaths is required by law to refuse registration and to report a death to the Coroner if the MCCD does not comply with legal requirements. It is ultimately the responsibility of the Consultant in Charge of the patient’s care to ensure the death is properly certified, so for junior medical staff in any doubt when completing the MCCD, you should discuss this with your Consultant in the first instance.

4.2.3 You should clearly document in the medical records what has been recorded as the cause of death on the MCCD, or if you have been unable to complete a MCCD and have referred the matter to the Coroner.

4.2.4 It is important when completing the MCCD that you avoid inadequate or vague causes of death, the use of symbols or abbreviations. There is further guidance on completing the MCCD in the front of every booklet of MCCDs.

4.3 Sub heading 3

4.3.1 On occasion, however, you will need to report details of the events leading to the death of your patient to the Coroner. In broad terms, a death should be referred to the Coroner if:

- the cause of death is unknown or cannot be readily attributable to natural causes (including cases where treatment or care or lack of treatment or care may have contributed to the death)

- the deceased was detained (by Police, in prison or under the Mental health Act) or was subject to a Deprivation of Liberty Safeguard (DoLS)

- where there is any suggestion of violence contributing to the death

In most cases the decision to report a case to the Coroner should not provide you with any difficulty. However, for practical purpose, please see the more comprehensive list of reportable deaths at Appendix A.

4.3.2 It is for the Coroner to apply the test of whether something has contributed to the death, not you, so if there is any doubt as to the cause of death; it should be reported to the Coroner.

4.3.3 In some cases, however, the correct course of action to be taken may not be clear to you. If this happens you may find the following notes of use:

- Confusion may arise if you are unsure of the exact cause of death. If this happens you should ask yourself what are the most likely series of clinical events that have led to death. Remember that you are probably best placed to make such an analysis and that you should base this judgement on the balance of probabilities (rather than beyond reasonable doubt)
• When you have given thought to this you should consider what cause of death you honestly feel able to give. If you are only able to identify the terminal event e.g. bronchopneumonia and not an underlying illness which you think may have led to this you should then ask yourself if death was likely to be due to natural or unnatural causes. (For example, if the bronchopneumonia has arisen following immobility after trauma, then this is a sequence of events of which the Coroner must be made aware). Again you should apply the test of the balance of probabilities.

• If you decide that, although the process was not entirely clear, the illness was likely to be due to natural causes you should complete the death certificate and consider asking for permission to undertake a hospital post mortem to clarify the disease process.

4.3.4 If you remain uncertain as to whether or not you are able to complete the MCCD, you should in the first instance discuss the case with the Consultant in Charge of the patient’s care (whose ultimate responsibility it is to ensure that the death is properly certified). You may also find it helpful to telephone the Coroner’s Office for advice as to whether the death requires referral to the Coroner.

4.3.5 If after careful thought you believe that you cannot consider the death to be due to natural causes you are obliged to report the circumstances of the case to HM Coroner before issuing an MCCD. To aid the Coroner’s Office you should be prepared to provide a clear and concise account of the events leading to death, and have the medical records with you when you speak with the Coroner. It is then up to the Coroner to decide whether to investigate further, or whether the death can be registered from the doctor’s MCCD.

4.3.6 Remember, unless the Coroner decides to investigate the case you are still required to provide a certificate stating the likely cause of death and you should give the Coroner your views as to why you consider that the death was not due to natural causes since this is the test that both the Coroner and Registrar must apply. In most such cases the Coroner will undertake his own enquiry. Only in this circumstance is the burden of certification taken from you.

4.3.7 The Coroner may decide not to investigate the case further and will advise you accordingly. In this case you should record that advice in the deceased patient’s medical records and complete a death certificate. Junior medical staff in any doubt about the advice given by the Coroner’s Office and who may require further clarification should discuss the case with their Consultant. Consultant medical staff can obtain advice from the Trust Medical Director.

4.3.8 It is important that the family are kept informed if the death is to be referred to the Coroner, and that the reasons for the referral are explained to them.

5.0 Monitoring Compliance and Effectiveness

These guidelines will be reviewed every three years or sooner should the need arise.

6.0 Associated Documents

None.
7.0 References

Births and Deaths Registration Act 1953.

8.0 Definitions

MCCD – Medical Certificate of Cause of Death

9.0 Consultation

Trust Governance and Assurance Committee.
Appendix A

DEATHS REPORTABLE TO THE CORONER

A death MUST be reported to HM Coroner if:

- the cause of death is unknown or if you are in any doubt as to the cause of death;
- it cannot readily be certified as being entirely due to natural causes;
- the deceased was not seen by a doctor during their last illness, or within the 14 days prior to death, or viewed by a doctor after death;
- the death was during an operation / as a consequence of the operation, or before full recovery from the effects of the anaesthetic or was in anyway related to the anaesthetic (whether the patient dies on the table or afterwards, irrespective of the length of time involved after anaesthesia e.g. a cerebral anoxia case dying six months later). Normally, a death within 24 hours should always be referred;
- the death may be related to a medical / nursing procedure and / or treatment whether invasive or not, even if the procedure was necessary, appropriate and properly executed;
- the death may be due to a crime;
- there is any element of suspicious circumstances;
- there is any element of sudden or unexplained circumstances;
- there is any history of violence or the death may be due to or contributed to by violence;
- the death may be linked to an accident (whenever it occurred, even if prior to admission). This includes medical / nursing mishaps;
- there is any question of self neglect or neglect by others contributing to or causing the death;
- the death has occurred or the illness arisen during or shortly after detention in police or prison custody (including voluntary attendance at the police station);
- the deceased was detained under the Mental Health Act 1983;
- the deceased was subject to a Deprivation of Liberty Safeguard (DoLS)
- the death is linked with a termination of pregnancy;
- the death might have been caused or contributed to by the actions of the deceased him/herself (such as a history of drug or solvent abuse, self-injury or overdose, or other suicide attempts) either intentionally or unintentionally;
- the death could be due to or contributed to by industrial disease, poisoning or occupational injury, or related in any way to the deceased’s employment (e.g. mesothelioma, bladder cancer etc);
• the death is due to or contributed to by drugs, including therapeutic and prescribed drugs, where there is overdose, poisoning, idiosyncrasy or addiction involved;
• the death may be due to or contributed to by a fall or fracture;
• the death occurred during or shortly following physical restraint, either by hospital staff or others.

Further circumstances when a death should be referred to the Coroner are if:

• the body is unidentified;
• the death is due to malnutrition or exposure / hypothermia;
• the death may be due to acute alcohol poisoning (but not chronic addiction);
• the death may be due to lack of medical care;
• the death occurs within 24 hours of admission to hospital (unless the admission was purely for terminal care);
• in the event of a stillbirth there is any doubt whether the child was born alive (e.g. the foetus breathed or exhibited other signs of life);
• the deceased was receiving any form of war pension or industrial disability pension (however irrelevant the disability may appear to be) unless the death can be shown to be wholly unconnected;
• there are any other unusual or disturbing features to the case;
• Careful consideration should be given to reporting a death where there is, or is likely to be, an allegation or complaint of:
  (i) medical / nursing mismanagement; and / or
  (ii) inappropriate treatment; and / or
  (iii) the death is the subject of a (serious) untoward incident investigation.

There is no legal requirement to report a death in this situation, but careful thought should be given as to whether the Coroner needs to be made aware of the circumstances surrounding the death.

The above is not an exhaustive list of the circumstances under which a death should be reported to the Coroner but rather is intended as a guide for hospital based medical staff. Junior medical staff who are uncertain about whether to report a death to the Coroner should, in the first instance, discuss the case with their Consultant. Consultant medical staff can obtain advice from the Trust Medical Director. Advice can also be sought from the Coroner’s Office.
Useful reminders:

- It is an offence to move or otherwise interfere with a body or surrounding evidence, without leave of the Coroner, where death has occurred in circumstances which may lead him to hold an Inquest:

  (i) For deaths occurring during or as a result of anaesthesia or any operative procedure or invasive technique involving any clinical support equipment (e.g. intubation tubes, catheters, probes, intravenous lines etc.), this should be left in situ for post mortem observation.

  (ii) If there is any doubt as to whether a death is to be referred to the Coroner, clinical support equipment should not be removed.

  (iii) Where needles or other sharps are present in the body at death and are left in situ the Consultant Histopathologist performing the post mortem should be notified. Staff are reminded that certain religions will need the body to be released very quickly. Difficulties can be encountered where the death has to be reported to the Coroner. It is, therefore, important that the Coroner is made aware of any such requirement and in turn that the next of kin are kept fully informed of any likely delays.

- It is vital that all discussions with the Coroner are fully recorded in the patient’s medical records including reasons for the referral. If it is possible to complete the MCCD, the cause of death recorded should also be documented in the patient’s medical records.